APPENDIX A

COBRA FORMS FOR HEALTH INSURANCE

FOR A PRINTABLE VERSION OF ALL FORMS, PLEASE GO TO THE OPEHI'S WEBSITE AT:

http://personnel.ky.gov/hlthins/adminifo.htm.

M E M O R A N D U M

TO: ______________________________

(Eligible Employee and Spouse, if any)

____

(Employee's Social Security Number)

FROM:

Insurance Coordinator

DATE:

GENERAL NOTICE OF RIGHT TO CONTINUE GROUP HEALTH INSURANCE COVERAGE

On April 7, 1986, a federal law, the Consolidated Omnibus Budget Reconciliation Act (COBRA) was enacted requiring that most employers sponsoring group health plans offer employees and their families the opportunity for a temporary extension of health coverage at group rates in certain instances where coverage under the plan would otherwise end. This section is intended to inform you of your rights and obligations under the COBRA provisions of the law. **Both you and your spouse should take the time to read this section carefully.**

If you are an eligible member under the Commonwealth of Kentucky's Public Employee Health Insurance Program, you have a right to choose temporary continuation coverage if you lose your group health insurance coverage because of a reduction in your hours of employment or the termination of your employment (for reasons other than gross misconduct on your part).

If you are the spouse or dependent child of an employee covered by the Plan, you have the right to choose temporary continuation coverage for yourself if you lose group health insurance coverage under the Plan for *any* of the following reasons:

(1) death of your spouse/employee;
(2) termination of your spouse's/employee's employment (for reasons other than gross misconduct) or a reduction in your spouse's/employee's hours of employment;
(3) divorce or legal separation from your spouse;
(4) your spouse becomes entitled to Medicare or
(5) dependent child ceases to be eligible under the spouse/employee Plan.

Definition of Qualified Beneficiary – A qualified beneficiary generally is an individual covered by a group health plan on the day before a qualifying event who is either an employee, the employee's spouse, or an employees dependent child. In certain cases, a retired employee, the retired employee's spouse, and the retired employee's dependent children may be qualified beneficiaries. In addition, any child born to or placed for adoption with a covered employee during the period of COBRA coverage is considered a qualified beneficiary.

“Qualifying Events” are certain events that would cause an individual to lose health coverage. The type of qualifying event will determine who the qualified beneficiaries are and the amount of time that a plan must offer the health coverage to them under COBRA.

Your Responsibilities – Under the law, you and your family member(s) have the responsibility to inform your Insurance Coordinator of a divorce, legal separation, or a child losing dependent status under the Plan within 60 days of the date of the event.

The Commonwealth has the responsibility to notify your Insurance Coordinator of the employee’s death, termination of employment, reduction in hours of employment, or Medicare entitlement. Similar rights may apply to certain retirees, spouses, and dependent children if the Commonwealth commences a bankruptcy proceeding and these individuals lose coverage.

When your Insurance Coordinator is notified that one of these events has happened, your Insurance Coordinator will, in turn, notify you that you have the right to choose temporary continuation coverage. Under the law, you have at least 60 days from the date you lose coverage because of one of the events described above to inform your Insurance Coordinator that you want temporary continuation coverage. If you do not choose temporary continuation coverage on a timely basis, your group health insurance coverage under the Plan will end.

If you choose temporary continuation coverage, the Commonwealth is required to provide you coverage, as of the time coverage is being provided, identical to the coverage provided under the Plan. A change in the plan for active employees will also apply to qualified beneficiaries. The law requires that you be afforded the opportunity to maintain continuation coverage for 36 months unless you lost your group health insurance coverage because of a termination of employment or a reduction in hours worked. In that case, the required temporary continuation coverage period is 18 months. The 18 months may be extended to 36 months if another qualifying event (such as death, divorce, legal separation, or Medicare entitlement) occurs during the original 18-month period.

Disability Extension – Qualified beneficiaries who wish to take advantage of the 11-month disability extension must notify plan administrators of the disabled qualified beneficiary’s Social Security disability determinations. A notice must be provided within 60 days of a disability determination and prior to expiration of the initial 18-month period of COBRA coverage. These beneficiaries also must notify the employee’s insurance coordinator within 30 days if the qualified beneficiary is determined by Social Security to be no longer disabled.

In no event will temporary continuation coverage last beyond 36 months from the date of the original qualifying event that made a qualified beneficiary eligible to elect temporary continuation coverage.

Termination of Coverage – However, the law also provides that your temporary continuation coverage may be terminated for *any* of the following reasons:

(1) the Commonwealth no longer provides group health insurance coverage to any of its employees;

(2) the required premium for your temporary continuation coverage is not paid on time;
(3) after the date that temporary continuation coverage is elected, the qualified beneficiary becomes covered under another group health plan that does not contain any exclusion or limitation with respect to any pre-existing condition he or she may have;
(4) after the date that temporary continuation coverage is elected, the qualified beneficiary becomes entitled to Medicare; or
(5) a qualified beneficiary extends coverage for up to 29 months due to disability and there has been a final determination that the individual is no longer disabled.

Duration of COBRA Coverage – There are situations in which a group health plan may terminate temporary continuation coverage earlier than usually permitted. One of these situations is where the qualified beneficiary obtains coverage under another group health plan. However, if the other group health plan contains a pre-existing condition limitation that affects you, your COBRA coverage cannot be terminated. HIPAA restricts the extent to which group health plans may impose pre-existing condition limitations. HIPAA coordinates COBRA's termination based on other coverage rules, as follows. If a group health plan limits or excludes benefits for pre-existing conditions, but because of the HIPAA rules those limits or exclusions would not apply to (or would be satisfied by) an individual receiving COBRA coverage, then the plan providing COBRA coverage may terminate your COBRA coverage.

You do not have to show that you are insurable to choose temporary continuation coverage. Under the law, you may have to pay all or part of the premium for your temporary continuation coverage. There is a grace period of at least 30 days for payment of the regularly scheduled premium. At the end of the 18 month, 29 month, or 36 month temporary continuation coverage period, qualified beneficiaries will be allowed to enroll in an individual conversion health insurance plan provided under the terms of the Plan.

If you have any questions about COBRA, please contact _____________, your Insurance Coordinator. Also, if you have changed your marital status, or you or your spouse has changed addresses, please notify your Insurance Coordinator.

COBRA
HEALTH INSURANCE *(EMPLOYEE)*
SAMPLE LETTER

(USE YOUR AGENCY LETTER HEAD)

MEMORANDUM

TO: ____________________________________
(*Eligible Employee and/or Dependents*)

____
(*Social Security Number*)

FROM: ____________________________________
(Insurance Coordinator)

SUBJECT: Notification of Rights for Continuation of Health Insurance Coverage/COBRA

DATE OF NOTIFICATION: ________________________________

This letter is to inform you that the last day you will be covered under the state health insurance plan will be **______________** unless you elect Consolidated Omnibus Budget Reconciliation Act ("COBRA") continuation coverage. Claims for covered health care services rendered after this date will not be paid unless you elect to continue your coverage under COBRA. Before making your choice to elect COBRA coverage you need to be aware of several issues: (1) how do you become eligible for COBRA; (2) whether COBRA coverage is available for dependent children; (3) how long the coverage shall last; (4) how premiums payments are made; and (5) what procedure must be followed to secure COBRA continuation coverage.

COBRA Eligibility

An employee health insurance plan participant becomes eligible for COBRA by experiencing a qualifying event. If you have been terminated from employment, had your hours reduced, or are on LWOP, then you have experienced a qualifying event and may elect COBRA continuation coverage.

Dependent Eligibility

All qualified beneficiaries are eligible for COBRA continuation coverage. If any dependent or spouse was covered under the participant's health insurance plan, then they are also eligible for COBRA continuation coverage by virtue of being a qualified beneficiary. COBRA continuation coverage will also be available to any dependent child(ren) born to or placed for adoption with you so long as your COBRA coverage is active. Each qualified beneficiary (your dependents) has a separate election right. If a qualified beneficiary does not elect COBRA continuation coverage within the 60-day period, all rights to elect such coverage will end.

Length of COBRA Coverage

This coverage may extend for 18 or 29 months depending on the circumstances. The general rule is that the participant is entitled to 18 months of continuation coverage; however, this may be extended by 11 months (for a total of up to 29 months) if you are declared disabled by the Social Security Administration. You may request the additional 11 months, as long as you apply for the extension within 60 days after the determination of disability by Social Security, and before the end of the original 18-month period, by notifying your insurance coordinator or:

Personnel Cabinet, Member Services Branch
200 Fair Oaks Lane, 5th Floor, Suite 502
Frankfort, Kentucky 40601

The 11-month extension applies to all disabled and non-disabled qualified beneficiaries entitled to COBRA coverage under your plan.

Payment of Premiums

The carrier will bill employees monthly for COBRA premiums. **<u>FAILURE TO PAY PREMIUMS ON TIME WILL RESULT IN TERMINATION OF COVERAGE</u>**. Premium rates are subject to change annually at the end of a contract year. You will be notified regarding any rate changes. Payments are considered timely only if they are received within 30 days of the due date. The first payment should be included with the Election Form and Application, but in no event should payment be later than 45 days from the date you sign these forms. The first payment must make coverage current (e.g. if the first payment is made three months after termination, the check must include three months of premium to update coverage).

COBRA Procedure

The following qualifying event entitles you to continue your health insurance coverage under COBRA for 18 months (29 months if declared disabled by the Social Security Administration):

______ Termination of employment
______ Reduction of hours
______ LWOP

The date of your qualifying event is ____________________ (COBRA continuation period starts on this date).

If you decide **NOT** to continue your coverage, please indicate this on the attached COBRA Election Form and return to my office as soon as possible.

If you decide to continue coverage, proceed with the following:

1. Complete the attached COBRA Election Form and Health Insurance Application.
2. Return the COBRA Election Form, Insurance Application, and first months premium payment made payable to the appropriate Carrier to:

   NAME: ______________________________________

   AGENCY: ______________________________________

   ADDRESS: ______________________________________

   The completed Election Form and Insurance Application must reach the Office of Public Employee Health Insurance office within 60 calendar days of either the date you lost coverage or the date you received this notification letter, whichever occurred later. If you fail to notify this office within 60 days then your health insurance with the state plan will terminate and you will permanently lose your right to elect COBRA continuation coverage.

3. Make your first payment with the Election Form and Application no later than 45 days from the date you sign these forms. The first payment must make coverage current (e.g. if the first payment is made three months after termination, the check must include three months of premium to update coverage).

4. Monthly premium payments are due on the first day of the month for which they apply. You have a 30-day grace period from the first day of each month in which to make your payment. All monthly payments must be postmarked on or before 30 days from the first day of each month.

   Although your initial payment must be submitted (along with your COBRA election form and application) to your coordinator, subsequent payments must be sent DIRECTLY TO THE INSURANCE CARRIER (MADE PAYABLE TO THE INSURANCE CARRIER) at the address listed below:

   ____
   Insurance Company

   ____
   Address

   ____
   City, State, and Zip Code

5. The monthly COBRA premiums for (*Plan name, Type, and Option level)* are:

$__________ for single coverage $__________ for couple coverage
$__________ for parent plus coverage $__________ for family coverage

COBRA health insurance coverage begins on the date of the qualifying event _______________and continues through __________________.

If ANY of the following circumstances occur, coverage will terminate immediately: (1) the former employer ceases to offer a plan; (2) you fail to pay premiums in a timely manner; (3) you become covered under another group health plan that does not have a pre-existing condition limitation; or (4) you become entitled to Medicare.

Once COBRA is elected, you are entitled to participate in the annual Open Enrollment. You will receive Open Enrollment information from your carrier.

See your Public Employee Health Insurance Handbook for more details regarding your COBRA rights.

All other insurance and deductions made from your paycheck will cease unless converted. For conversion procedures, contact the companies with which you are insured or have deductions. Our records indicate that you have the following additional insurance and/or deductions:

(LIST EMPLOYEE'S PAYROLL DEDUCTIONS)

If you wish to withdraw your retirement contributions and you have not already signed the necessary forms, you should contact your Retirement System.

If you have questions, please contact *(List agency contact name and phone number).*

Enclosures

COBRA
HEALTH INSURANCE *(DEPENDENTS)*
SAMPLE LETTER

(USE YOUR AGENCY LETTER HEAD)

MEMORANDUM

TO: ______________________________ ______________________________
(***Employee Spouse or Dependent***) (***Employee Name***)

______________________________ ______________________________
(***Social Security Number***) (***Social Security Number***)

FROM: ______________________________________
(Insurance Coordinator)

SUBJECT: Notification of Rights for Continuation of Health Insurance Coverage/COBRA

DATE OF NOTIFICATION: ____________________________________

This letter is to inform you that your dependent coverage under the state-sponsored health insurance plan will terminate on __________________, unless you elect to continue your coverage under the Consolidated Omnibus Budget Reconciliation Act (COBRA). Claims for covered health care services rendered after this date will not be paid unless you elect to continue your coverage under COBRA. Before making your choice to elect COBRA coverage you need to be aware of several issues: (1) how do you become eligible for COBRA; (2) whether COBRA coverage is available for dependent children; (3) how long the coverage shall last; (4) how premium payments are made; and (5) what procedure must be followed to secure COBRA continuation coverage.

COBRA Eligibility

A dependent or spouse health insurance plan participant becomes eligible for COBRA by experiencing a qualifying event. The following events are qualifying events that permit a dependent to elect COBRA continuation coverage: (1) termination of spouse or parent that was covered under the state-sponsored plan; (2) a reduction in that employee's hours; (3) the employee goes on Leave Without Pay ("LWOP"); (4) death of the employee; (5) the spouse is divorced or legally separated from employee; (6) employee becomes entitled to Medicaid; and (7) dependent child ceases to be an eligible dependent. Upon the occurrence of the event each dependent or spouse has a separate right to elect COBRA continuation coverage and a failure to do so within 60 days waives any right to ever elect COBRA coverage.

Dependent Eligibility

All qualified beneficiaries are eligible for COBRA continuation coverage. If any dependent or spouse was covered under the participant's health insurance plan, then they are also eligible for COBRA continuation coverage by virtue of being a qualified beneficiary. COBRA continuation coverage will also be available to any dependent child(ren) born to or placed for adoption with you so long as your COBRA coverage is active. Each qualified beneficiary (your dependents) has a separate election right. If a qualified beneficiary does not elect COBRA continuation coverage within the 60-day period, all rights to elect such coverage will end.

Length of COBRA Coverage

This coverage may extend for 18, 29, or 36 months depending on the circumstances. The general rule is that the participant is entitled to 18 months of continuation coverage; however, this may be extended by 11 months (for a total of up to 29 months) if you are disabled within the first 60 days of the original effective date of your COBRA continuation coverage, as defined under Title II or XVI of the Social Security Act. You may request the additional 11 months, as long as you apply for the extension within 60 days after the determination of disability by Social Security, and before the end of the original 18-month period, by notifying:

Personnel Cabinet, Member Services Branch
200 Fair Oaks Lane, 5th Floor, Suite 502
Frankfort, Kentucky 40601

The 11-month extension applies to all disabled and non-disabled qualified beneficiaries entitled to COBRA coverage under your plan.

In addition, the COBRA continuation coverage is available for a maximum of 36 months for several qualifying events: member becoming eligible for Medicaid, dependent child ceases to be an eligible dependent, divorce or legal separation, and death of the employee. All COBRA coverage shall terminate at the end of the maximum period, if the employer terminates its health insurance plan, or the dependent or spouse becomes covered under another group health plan, whichever occurs first.

Payment of Premiums

The carrier will bill employees monthly for COBRA premiums. **FAILURE TO PAY PREMIUMS ON TIME WILL RESULT IN TERMINATION OF COVERAGE**. Premium rates are subject to change annually at the end of a contract year. You will be notified regarding any rate changes. Payments are considered timely only if they are received within 30 days of the due date. The first payment should be included with the Election Form and Application, but in no event should payment be later than 45 days from the date you sign these forms. The first payment must make coverage current (e.g. if the first payment is made three months after termination, the check must include three months of premium to update coverage).

COBRA Procedure

The following qualifying event entitles you to continue your current health insurance coverage under COBRA:

[ ] Termination of Employee***** (18 months)
[ ] Reduction of Employee's hours*, or (18 months)
[ ] Employee goes on LWOP* (18 months)
[ ] Death of employee (surviving spouse and dependent children - 36 months)
[ ] Divorce or legal separation (36 months)
[ ] Member becomes entitled to Medicare (dependent - 36 months)
[ ] Dependent child ceases to be an eligible dependent (36 months)

**** 29 months if declared disabled by the Social Security Administration***

The date of your qualifying event is ______________(18, 29 or 36 months is counted from this date).

The last date you will be covered by Public Employee Health Insurance will be__________________ unless you elect COBRA. *(end of month following month of qualifying event).*

If you decide NOT to continue your coverage, please indicate this on the attached COBRA Election Form and return to my office as soon as possible.

Each dependent has a separate election right. If a dependent does not elect COBRA continuation coverage within the 60 day period, all rights to elect such coverage will end.

If you decide to continue coverage, proceed with the following:

1. Complete the attached COBRA Election Form and Health Insurance Application.
2. Return the COBRA Election Form, Insurance Application, and first months premium payment (made payable to the appropriate Carrier) to:

NAME: ____

AGENCY: ____

ADDRESS: ____

The completed Election Form and Insurance Application must reach the Office of Public Employee Health Insurance within 60 calendar days of either the date you lost coverage or the date you received this notification letter, whichever occurred later. If you fail to notify this office within 60 days then your health insurance with the state plan will terminate and you will permanently lose your right to elect COBRA continuation coverage.

3. Make your first payment with the Election Form and Application, but in no event should payment be later than 45 days from the date you sign these forms. The first payment must make coverage current (e.g. if the first payment is made three months after termination, the check must include three months of premium to update coverage).

4. Monthly premium payments are due on the first day of the month for which they apply. You have a 30-day grace period from the first day of each month in which to make your payment. All monthly payments must be postmarked on or before 30 days from the first day of each month.

   Although your initial payment must be submitted (along with your COBRA election form and application) to your coordinator, subsequent payments must be sent **DIRECTLY TO THE INSURANCE CARRIER (MADE PAYABLE TO THE INSURANCE CARRIER**) at the address listed below:

   ____
   Insurance Company

   ____
   Address

   ____
   City, State, and Zip Code

5. The monthly COBRA premiums for ____ are: (*Plan name, Type, and Option level)*

$__________ for single coverage $__________ for couple coverage
$__________ for parent plus coverage $__________ for family coverage

COBRA (health insurance coverage) would begin ________________________
and continues through ____________________.

If ANY of the following circumstances occur, coverage will terminate immediately: (1) the former employer ceases to offer a plan; (2) you fail to pay premiums in a timely manner; (3) you become covered under another group health plan that does not have a pre-existing condition limitation; or (4) you become entitled to Medicare.

Once COBRA is elected, you are entitled to participate in the annual Open Enrollment. You will receive Open Enrollment information from your carrier.

6. The 18 months of continuation coverage may be extended by 11 months (for a total of up to 29 months) if you are determined to be disabled (under Title II or XVI of the Social Security Act) within the first 60 days of the original effective date of your COBRA continuation coverage. You may request the additional 11 months, as long as you apply for the extension within 60 days after the determination of disability by Social Security, and before the end of the original 18-month period, by notifying:

   Personnel Cabinet, Member Services Branch
   200 Fair Oaks Lane, 5th Floor, Suite 502
   Frankfort, Kentucky 40601

   The 11-month extension applies to all disabled and non-disabled qualified beneficiaries entitled to COBRA coverage under your plan.

   Employees will be billed monthly for COBRA premiums by the carrier. As referenced above, **FAILURE TO PAY PREMIUMS ON TIME WILL RESULT IN TERMINATION OF COVERAGE**. Premium rates are subject to change annually at the end of a contract year. You will be notified regarding any rate changes. Payments are considered timely only if they are received within 30 days of the due date.

If you have questions, please contact ____.
(Agency Contact Name & Phone Number)

Enclosures

COBRA ELECTION FORM
PUBLIC EMPLOYEE HEATH INSURANCE PROGRAM

Acceptance of COBRA Continuation Coverage

I have read the Notification of Rights to Continue Health Insurance Coverage/COBRA and this COBRA Election Form. I understand I have the right to elect COBRA continuation coverage, effective ______________________. I also understand that if I fail to pay my premiums on time, the COBRA continuation coverage will end. I further understand and agree to notify my insurance company if I, or any member of my family, becomes (1) covered under another group health plan or (2) entitled to Medicare benefits after this election of COBRA coverage.

This election to accept COBRA continuation coverage is applicable to:

☐ Employee only ☐ Employee and spouse ☐ Employee and child(ren)

☐ Employee, spouse, and child(ren) ☐ Spouse and child(ren)

☐ Spouse only ☐ Child(ren) only

Waiver of COBRA Continuation Coverage

I have read the Notification of Rights to Continue Health Insurance Coverage/COBRA and this COBRA Election Form. I voluntarily **waive/decline** my right to COBRA continuation coverage with regard to the Commonwealth Health Insurance Plan.

This election to voluntarily waive COBRA continuation coverage is applicable to:

☐ Employee only ☐ Employee and spouse ☐ Employee and child(ren)

☐ Employee, spouse, and child(ren) ☐ Spouse and child(ren)

☐ Spouse only ☐ Child(ren) only

Employee Signature: ___________________________________ Date: _____________

Spouse Signature: ___________________________________ Date: _____________

Child Signature: ___________________________________ Date: _____________
(only if age 18 or older)

Employee Name (please print): _________________________ SSN#: _________________

Address ______________________________ Date of Birth: _______________________

______________________________ Phone No.: _______________________

Received by Insurance Coordinator: _______________________ Date: ____________